

CHOICES FOR CARE
Home-Based & ERC Change Form

This form is completed by the Choices for Care case manager/consultant to report changes for active or Medicaid pending Home-Based or ERC Choices for Care participants.

Individual Name: _____

Address (only if changed): _____

SSN: _____ Date of Birth: _____

Current Setting: ☐ Home-Based -OR- ☐ Enhanced Residential Care

A. Nursing Facility (or Hospital Swing Bed) Admission

Effective date of admission: _____

☐ Permanent or ☐ Temporary - Estimated length of stay: _____

Nursing Facility (or Hospital Swing Bed): _____

B. Termination /Withdrawal from Choices for Care Program

NOTE: For home-based consumer or surrogate-directed services or case & counseling services the case manager or consultant must forward a copy to ARIS.

Effective date: _____

☐ Died

☐ Permanent move out of state

☐ *Voluntary Withdrawal – No longer require Choices for Care services

☐ Other: _____

*For voluntary withdrawals, the individual or legal representative must sign below. Individuals who are involuntarily terminated from Choices for Care will receive a written notice with appeal rights.

I agree that I am voluntarily withdrawing from Choices for Care program. I understand that I may reapply at any time.

 Individual or Legal Representative Signature

 Date

Comments if needed:

Case Manager Name (print): _____

Agency: _____ Phone number: _____

Signature: _____ Date: _____

Copy to local DAIL LTCCC and DCF office.

Directions

This form is completed by the Choices for Care case manager or consultant for cash & counseling option to report changes for **active or Medicaid pending** participants in the Home-Based or Enhanced Residential Care setting. When completing the Change Report Form, complete all sections that apply.